2009 Medicaid Transformation Program Review
Surveillance and Utilization

Description

KHPA contracts with HP Enterprise Services (formerly EDS) for the operations of its Surveillance and Utilization Review Subsystem (SURS) to meet the federal mandates contained in 42CFR455 and 42CFR456 and to fulfill its program management objectives. SURS staff utilizes various tools to conduct reviews of fee for service providers and consumers. The SURS system includes a fraud and abuse detection system (FADS) owned by the Fair Isaac Corporation (FICO) which ranks providers and claims to help identify and investigate providers who potentially misuse the services. HP Enterprise Services also uses tools such as the DSSProfiler that have been created and are in high demand throughout the insurance industry. The DSSProfiler is an integrated query, reporting, and analysis tool that uses information from the Decision Support System (DSS) Database. The information in the DSS Database is pulled from the Medicaid Management Information System (MMIS). The DSSProfiler enables comparisons between and among provider and beneficiary peer groups.

KHPA contracts with Kansas Foundation for Medical Care (KFMC) to conduct reviews on fee for service inpatient hospital claims. KFMC reviews a sample of inpatient claims drawn from the MMIS and DSSProfiler for overpayments and medical necessity.

The Managed Care Organizations are responsible for the integrity of Managed Care Encounter Claims. This includes encounter data submitted by the Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP).

SURS activities are conducted by HP Enterprise Services who maintained a utilization review staff that includes ten nurses and two social workers who, using their clinical expertise, analyze computer generated reports, conduct reviews of individual utilization patterns, and follow through with appropriate corrective actions when warranted. Provider reviews are conducted to identify potential overpayments, potential fraud, and MMIS systems issues. Staff also assesses medical necessity and quality of care. Consumer reviews are conducted to monitor the utilization of medical services by consumers. A flow chart of the SURS process and timelines for provider reviews is contained in Appendix A.

Post-pay claims reviews of fee for service providers are initiated due to referrals, profile and targeted query reports, and re-reviews of providers. The number of reviews per quarter may vary depending on the quantity of referrals for a full review. Referrals may come from KHPA or other State staff or from HP Enterprise Services staff. Full reviews consist of record reviews to determine potential overpayments, medical necessity, potential fraud, systems issues, and quality of care provided to the beneficiary. Focused reviews target specific billing issues identified across provider groups and may not require record reviews. Focused reviews are often identified by targeted queries using the FADS tools. An average of 31 provider reviews and four Home and Community Based Services (HCBS) reviews are assigned each quarter.

There are several steps involved in a full review. The process involves an initial claims review, a records request, initial findings, review of rebuttal information, and a final determination. The provider is given the opportunity to review the findings and submit rebuttal documentation throughout the process. Once the final determination is made, the provider has an opportunity for Administrative Reconsideration and Appeal. A formal appeal may take anywhere from six months to several years, depending upon how far the provider or State appeals the case. The case may be appealed first to the Office of Administrative Hearings, then to the State Appeals Committee, then to the District Court level. While focused reviews do not always involve records reviews, providers still have options to provide rebuttal documentation and to appeal. Cases remain open until all appeal options have been exhausted. For this reason, the number of cases opened each quarter does not correspond to the number of cases closed. In addition, dollars identified for recoupment each quarter does not correspond to the dollars actually recouped. Some accounts receivables remain open from one to two years. Others are never collected due to providers going out of business. The amount of costs avoided due to the deterrent factor of SURS reviews cannot be calculated.

HP Enterprise Services began capturing the dollars recouped from SURS reviews in the second quarter of SFY 2007, so three quarters of data are available for SFY 2007. This was due to a change that was made in the MMIS that allowed this data to be captured. No data is available for SFYs 2005 and 2006. The SURS unit calculates the dollars identified for recoupment from full reviews separately from the dollars identified from focused reviews. However, the time spent identifying these dollars is not sufficiently tracked to determine the effectiveness of the process. Doing so in the future could assist in evaluating the tools and methods used to identify aberrant billing patterns. Finally, the SURS Unit does not currently extrapolate statistically valid random sample findings to providers' entire claims universe. This practice was ceased at the request of KHPA when a concern was identified regarding identifying the claims during OIG and other audits and mass adjustments. The claims were adjusted as a whole, not individually, making it appear as if errors in individual claims had not been corrected. The option to resume extrapolation may be explored once this issue has been resolved.

Pre-payment review monitoring is a process in which new claims are suspended until supporting documentation has been reviewed by an analyst. KHPA utilizes pre-payment review in cases where questionable billing practices or very poor documentation have been identified in previous reviews. For example, providers whose documentation did not support the services billed or who failed to provide documentation during a SURS review may be placed on pre-payment review. Claims denied during the course of pre-payment review are identified as costs avoided. Frequently, providers who have had their claims denied during a pre-payment review stop billing Medicaid, so the costs avoided are limited.

If fraud is suspected at any time during the course of a provider review, the provider is referred to the Kansas Attorney General's Medicaid Fraud Control Unit (MFCU). Fraud is defined in 42CFR455 as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. KHPA is mandated to report all instances of suspected provider fraud to the MFCU in 42 CFR 455.15. Fraud referrals may come from KHPA employees as well as from HP Enterprise Services. It is the responsibility of the MFCU to determine if fraud has occurred. KHPA and HP Enterprise Services employees often continue to work with the MFCU on gathering information on cases and testifying during criminal proceedings. KHPA, HP Enterprise Services, and representatives from KHPA Managed Care Organizations meet regularly with MFCU to discuss ongoing cases and trends and issues in Medicaid fraud such as Dentists requiring patients to make return visits to work on different teeth in the same quadrant and Durable Medical Equipment providers who provide standard wheelchairs and bill Medicaid for power wheelchairs.

Consumer Reviews monitor the utilization of medical services by the consumer. This is accomplished by developing profiles of provider and consumer cases for the review of medical necessity of services, quality of care issues, over utilization and under utilization of services rendered, and adherence to

established program guidelines. The Fraud Analyst identifies consumers to be reviewed from referrals and from scheduled lock-in and post-education reviews. Cases are opened in each quarter according to guidelines established by KHPA. Reviewers complete a desk review of the consumer's utilization of providers, pharmacies, and prescriptions. If further research is necessary to determine if the consumer should be placed on lock-in, the case is advanced and the reviewer initiates a detailed research of the information previously obtained. This may include contacting providers and consumers to substantiate information and requesting written documentation as needed to verify services provided.

Cases are referred to Lock-in when it has been confirmed there is abuse or misuse of services and lock-in is recommended in lieu of education. Lock-in limits the consumer to one physician, one pharmacy, and one hospital.

The cost avoidance dollar amount is estimated each year based upon an analysis of the previous years' data. The data includes Lock-in beneficiary claims information for the pre- and post-lock-in period. The estimated amount varies in comparisons from year to year and is influenced by the health status of the beneficiaries. Outliers are not excluded from the analysis and account for wide variations in some years.

Review Activities, Expenditures, and Fiscal Savings

SURS analysts spend their time on a variety of activities in support of program integrity. The following is a list of activities and the approximate percentage of time spent on the activities:

- Eighty-five percent of twelve analysts' time is used to complete both provider and consumer reviews;
- Sixty-five percent of one full time equivalent (FTE) and approximately three percent of the analysts' time is used for appeal preparation, testimony, and depositions;
- Twenty percent of one FTE and one percent of the analysts' time is spent making referrals to the MFCU;
- Five percent of one FTE and approximately three percent of the analysts' time is spent working with the MFCU and US Attorney on case preparation and criminal testimony;
- Ten percent of one FTE, 50% of another FTE, and eight percent of analysts' time is spent preparing data requested by KHPA and others.

In addition to the above, the SURS Unit "loaned" from one to three and one-half FTEs to the MFCU and the United States Attorney's office to provide assistance in fraud investigations in State Fiscal Years 2007 and 2008. Table 1 illustrates the breakdown of the analysts' time.

Table 1 - Distribution of SURS Analysts' Time

Activity						
Description	Provider & Consumer Reviews	Appeal Preparation	MFCU Referrals	MFCU and US Attorney Case Preparation	Data Requests	Assist US Attorney and MFCU
% of Time	85%	65% / 3%	25%	5% / 3%	10% / 50% / 8%	100%
FTEs	12	1 / 12	1	1 / 12	1 / 1 / 12	1 - 3 1/2

HP Enterprise Services submits monthly reports, called Cost Avoidance and Recovery Evaluations (CARE), to KHPA. CARE reports detail the number of provider and consumer reviews initiated and closed, dollars identified for recoupment and dollars recouped, costs avoided due to Lock-In, the number of providers on pre-payment review and the costs avoided, and the number of fraud referrals made to the MFCU. The reports also track the status of provider cases currently under review and on appeal.

Figure 1 summarizes the activities of the HP Enterprise Services SURS Unit for the last four state fiscal years. Figure 2 delineates SURS unit outcomes. Information contained in the table was taken from the CARE reports. Costs recovered and costs avoided were combined to arrive at the percentage of the cost of recovery and avoidance.
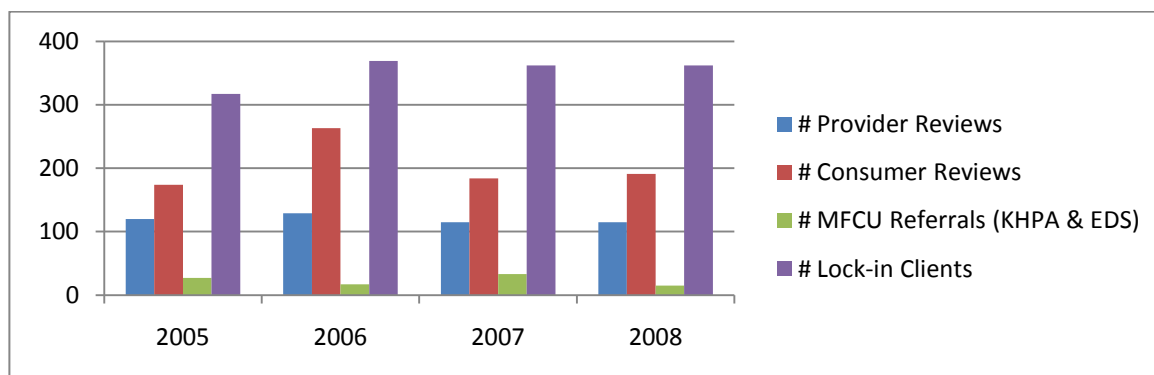
Figure 1- SURS Unit Activity by Fiscal Year

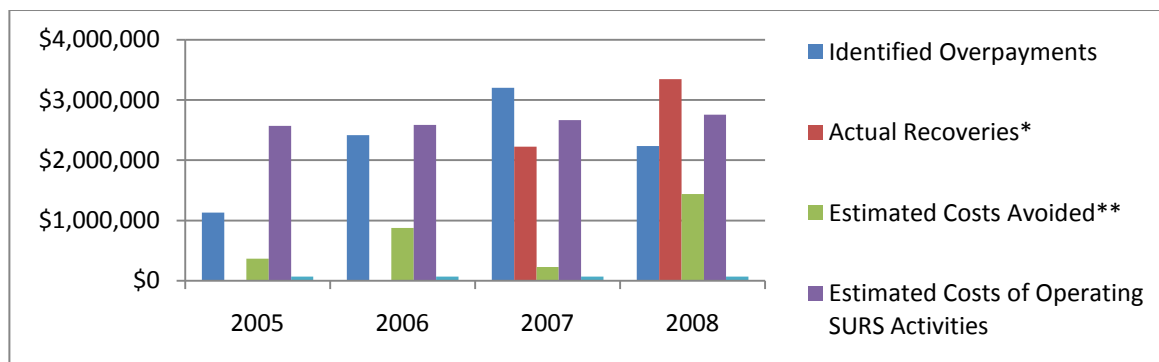**Figure 2 – SURS Unit Savings and Expenditures**

Table 2 – SURS Unit Recoupments

State Fiscal Year	# Claims Reviewed	$ Identified for Recoupment and $ Recouped	Cost to State	Cost of Recoveries (% of $ Identified & $ Recouped to Cost to State
2005	25,620	$8,043,285	$1,310,013	16%
2006	27,237	$8,209,103	$1,310,013	16%
2007	26,383	$8,510,651	$1,408,882	17%
2008	15,281	$12,749,381	$911,256	7%

KFMC reviews a sample of fee for service inpatient hospital claims for overpayments and medical necessity. A new contract which began in SFY 2008 was negotiated with KFMC after the previous contract was released for competitive bid. The new contract resulted in reduced costs to the State with greater savings. However, KFMC was unable to complete all of the contracted claims reviews in SFY 2008 due to the data not being available from HP Enterprise Services until SFY 2009. These reviews and the costs were shifted to the contract cost in SFY 2009. KFMC staff also spends a small percentage of their time on appeal preparation and testimony. However, appeals of hospital claims reviews are rare and likely constitute less than one percent of the claims reviewed.

Dollars identified for recoupment from hospitals are recouped during the quarter they are identified.

KFMC submits detailed quarterly reports and an annual summary report to KHPA to monitor their activities. Table 3 summarizes the hospital utilization review activities of KFMC for the last four state fiscal years.

Table 3 – Hospital Recoupments Following KFMC Reviews
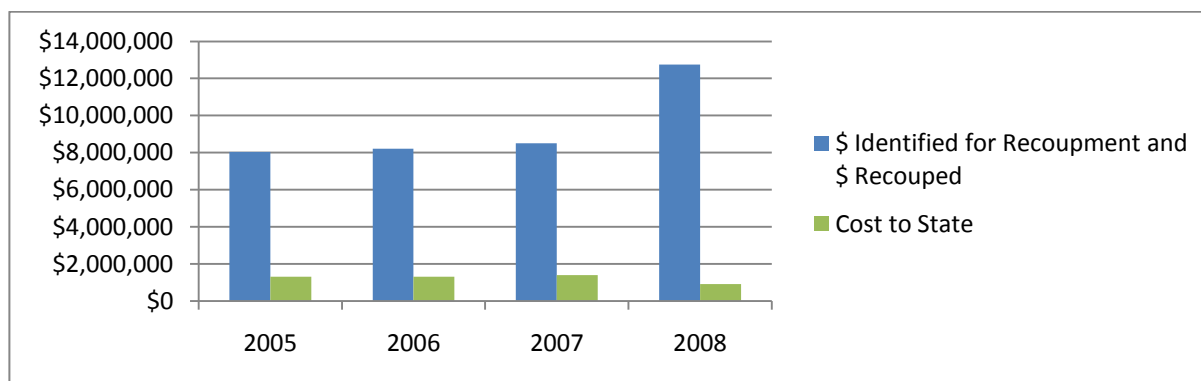
Program Evaluation

There are a number of initiatives on the national level that are relevant to SURS and other program integrity activities. Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid

Integrity Program in section 1936 of the Social Security Act (Public Law 109-171). The Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Group (MIG) is responsible for implementing the Medicaid Integrity Program (MIP). The MIG has two lines of business: Support and Assistance to States and Medicaid Integrity Contracting.

To support and assist states, the MIG contracted with the Department of Justice to establish the Medicaid Integrity Institute (MII). The MII is located on the campus of the University of South Carolina in Columbia, South Carolina. It focuses on developing a comprehensive program of study addressing aspects of Medicaid program integrity including fraud investigation, data mining and analysis, case development, and other topics specific to programs such as Home Health, Durable Medical Equipment, and Pharmacies. MII training is provided to State Medicaid Agency staff at no cost to the states. The KHPA SURS manager closely follows the national trends and activities of the MII and with other states in helping MII staff identify states' needs and course curriculum. Four KHPA staff attended the MII in federal fiscal year 2008. Six have attended thus far in federal fiscal year 2009, six are scheduled to attend in the next few months, and it is anticipated more will attend as the year progresses.

The MIG has also awarded umbrella contracts to five companies to review Medicaid providers. This is a departure from ongoing Federal oversight which focuses on state compliance with Federal rules. These Medicaid Integrity Contractors (MICs) will conduct post-payment audits of Medicaid providers. The program was designed to enhance, not duplicate, the states' program integrity efforts. The MICs will coordinate their efforts with State Program Integrity staff. Audits began last summer in two regions of the nation. It is anticipated that audits will begin in Kansas after September 2009.

The MIG has recently completed its first annual State Program Integrity Assessments (SPIA). This will be an annual process used by the MIG to collect data on program integrity activities on all the states, to develop profiles of each state, to determine areas to provide states with technical support and assistance, and to measure each state's performance. The results of the first year assessments have not yet been published. The MIG also conducts state program integrity reviews. The reviews encompass statutory and regulatory compliance, identification of best practices, identification of vulnerabilities, and opportunities for technical assistance. The purpose is to improve Medicaid program integrity nationally. States are on three year comprehensive review schedules. Kansas' first review is scheduled for federal fiscal year 2010.

KHPA prepared a study of best practices in program integrity for the 2009 Legislative Coordinating Council. Many of the national practices identified in this study are activities conducted by Surveillance and Utilization Review and have been implemented to various degrees in Kansas. The following are best practices for SURS that have been implemented or are capable of performing:

1. Cooperative relationships with Program Integrity, Medicaid Fraud Control Units, Offices of Inspector General, United States Attorneys, and active participation in Health Care Fraud Task Forces.
2. Pre-payment review monitoring in which new claims are suspended until they have been reviewed by an analyst.
3. Use of advanced data analysis and identification of aberrant providers.
4. State review of contractor's audit findings prior to recoupment.
5. Notification to various Boards (Healing Arts, Pharmacy, Nursing) when patterns of inappropriate activities are identified.
6. Conduct on-site visits to review provider records, meet with providers, and observe some of the services being provided.
7. An analysis of the amount of time billed by providers to determine if providers are billing for more than 24 hours per day.
8. Use of a standardized form for referrals of suspected fraud to the MFCU.

The following best practice is currently being initiated.

1. Receive referrals alleging fraud or abuse via Recipient Explanation of Medicaid
   benefits (REOMB). KHPA is currently in the process of improving the REOMBs to target specific
   provider types or beneficiary populations to reach populations more vulnerable to fraud and abuse
   without raising the cost. The current process selects beneficiaries randomly from all populations. One
   state reported initiating from two to four investigations per month from targeting REOMBs.

The following are best practices that are being explored for possible future use.

1. Random Pre-Payment Reviews: This process is an anti-fraud control strategy that
   puts providers on notice that all claims submitted for payment are at risk for review
   prior to payment. A pre-determined number of claims would be selected for review on
   a weekly basis. Providers would be required to submit documentation to support the
   payment before the claim is approved. Any claim that cannot be supported is denied
   for payment.

2. Provider Self Audits: This is a review of providers for deficiencies in their billing and
   request that the providers audit their own records. Providers repay the state if they
   identify an overpayment. One state claimed to have had over $2 million in collections
   in Federal Fiscal Year 2007 from this process.

Issues identified in internal program reviews may also be targeted for a review of billing practices.
Examples are home health and transportation. The focused, in-depth review of spending and policy
identified areas of high growth and over-spending sometimes due to opportunistic provider billing
behavior resulting in inappropriate payments. The Agency's commitment to publish and address problem
areas represents a new and novel practice that improves program integrity.

Recommendations

The SURS staff at HP Enterprise Services and the staff at KFMC utilize various tools to conduct reviews
of providers and consumers. The activities of SURS and KFMC meet federal mandates and have
resulted in significant cost savings. The KHPA SURS manager closely follows national trends and
activities, and many of the best practices identified at the national level have been implemented or
initiated. However, some improvements may be made to maximize the efficiency of the SURS program.
The following are specific recommendations that have resulted from this review:

1. Consider resuming the extrapolation of statistically valid random sample findings to providers'
   entire claims universes once the issue of identifying these claims as having been corrected has
   been resolved. This would avoid having these claims being identified as errors in outside audits
   and mass adjustments. A complete review of KHPA policies regarding extrapolations should be
   completed along with a comparison of other states' methods and CMS guidelines for
   extrapolations.

2. Calculate the dollars identified and time spent for recoupment from full reviews separately from
   the dollars identified and time spent from focused reviews. This would be done to assist in
   determining the effectiveness and possibly improving the selection process to maximize the
   SURS analysts' time and efforts. It would also aid in evaluating the tools used to identify aberrant
   billing patterns.

3. Complete the process of changing the REOMBs to target specific provider types or

beneficiary populations to reach areas more vulnerable to fraud and abuse and to increase referrals alleging fraud or abuse.

4. Explore other initiatives, such as the use of random pre-payment reviews and provider self audits, that were identified as best practices in the Legislative Coordinating Council study.

5. Continue to evaluate the effectiveness of the SURS and KFMC programs and the results of program initiatives to improve quality.

6. Continue to keep abreast of and participate in nationwide initiatives in Medicaid program integrity.

It is important to recognize that while SURS reviews serve as a deterrent to fraud and abuse and help identify areas where provider education is needed, they can also impact provider decisions to remain in the Medicaid program. Whether or not a SURS review results in negative findings, there is a burden on the provider to collect, copy, and submit documentation. Collecting and submitting rebuttal information and filing an appeal adds to that burden. If the provider is upheld on appeal, much effort has been exerted for no appreciable gain to the state and some negative perception of the Medicaid program on the part of the provider.

The Governor's recent 2010 budget allotment required a 10% payment reduction to Medicaid providers which could result in some loss of providers and less access to care for beneficiaries. Combined effects of SURS reviews and payment reductions could result in fewer providers; however, national emphasis is toward increased program integrity activities, as described in Appendix A (CMS Medicaid Integrity Strategy: 2010 – 2012). KHPA will monitor provider participation and determine if, and how, SURS reviews may contribute to loss of providers.

Appendix A

Medicaid Integrity Strategy: 2010 – 2012

<u>Goal</u>: *Protect the Medicaid program by strengthening the national Medicaid audit program while enhancing Federal oversight of and support and assistance to State Medicaid programs.*

The Centers for Medicare & Medicaid Services (CMS) faces enormous challenges in avoiding, deterring, and preventing improper payments across its programs. As part of the Agency's overall strategy to reduce improper payments, the Medicaid Integrity Program (MIP) will implement four major themes of action: data, measuring performance, mitigation through policy, and collaboration.

Data: The MIP will work to increase the utilization of Medicaid data to identify emerging fraud and abuse trends across and within States. We will work closely with States to obtain supplementary data and/or support files as needed.

Actions:
1) Complete evaluation of MSIS data to determine if the collection of additional elements adds value for program integrity.
2) Continue to develop algorithms and exercise use of sequence, outlier and link analysis to broaden Medicaid program capability for investigations, audits and reviews.
3) Continue to direct the national Medicaid audit program in a manner that generates high return on investment.

Measuring Performance: The MIP will strive to demonstrate achievable improvement in national PERM error rate while developing enhanced oversight and reporting mechanisms to evaluate the effectiveness of Federal and State PI efforts.

Actions:
1) Improve utilization of PERM findings and other measures to foster national improvements.
2) Redesign comprehensive State Program Integrity review tool.
3) Evaluate State Program Integrity Assessment (SPIA) tool.

Mitigation Through Policy: The MIP will promote PI awareness within the Federal Medicaid program and provide States with necessary tools to proactively and effectively deal with Medicaid fraud, waste and abuse.

Actions:
1) Develop and implement National Medicaid Alert System to regularly and quickly disseminate information to States on emerging schemes.
2) Incorporate consideration of program integrity vulnerabilities in new and existing programs.
3) Develop and publish a compendium of unacceptable payment errors for Medicaid (UPEMs) and a description of controls to prevent such errors. Incorporate evaluation of States' implementation of such controls into State PI reviews.

Collaboration: The MIP will strive to increase collaboration between Medicare & Medicaid program integrity efforts, between Federal and State Medicaid partners, and with other public and private insurance programs.

Actions:
1) Provide Federal support to large-scale State-run PI efforts.
2) Develop additional "best practices" guidance for States.
3) Work with States to promote business process improvements in areas such as provider enrollment, utilization review, data mining and law enforcement referrals.
4) Improve Medicaid – Medicare coordination in high vulnerability areas.